NOTICE OF INDEPENDENT REVIEW DECISION

Date: May 27, 2003

RE: MDR Tracking #: M2-03-0971-01
IRO Certificate #: 5242

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a Physical Medicine and Rehabilitation/Chiropractic physician reviewer who is board certified in Physical Medicine and Rehabilitation. The Physical Medicine and Rehabilitation physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History
The claimant is a 36 year old female. She is 5'3" in height and weighs approximately 140 pounds. She has a reported date of injury on ___ when working as a custodian. She states she was throwing a bag of trash weighing approximately 10 pounds into a dumpster when she experienced immediate back pain. She has remained under treatment since this time of injury.

Requested Service(s)
Pain Management Program by ___ at this time for continued low back pain with findings on 3-19-03 by examination showing positive straight leg raise to 10° on the left and 30° on the right by a chiropractor.

Decision
I agree with the insurance carrier that a chronic pain management program is not reasonable or medically necessary.

Rationale/Basis for Decision
After review of records, it appears this patient suffered a sprain/strain injury on ___, which should have cleared with or without treatment in 6 to 8 weeks. It appears there are emotional underlying components with the patient's recovery that were pre-existing this event. I agree with review by another chiropractor on 2-25-03 that this patient would benefit from ongoing psychological/psychiatric care, but it is not related to the event of ___. It appears the event on ___ exacerbated an underlying stress disorder that she was experiencing. She is reported taking care of a disabled brother which would, most likely, require repeated lifting and assisting him during the course of her activities of daily living which could be also be the source of her continued low back problems.

Therefore, I agree with the doctor's assessment on 2-25-03. This patient has been treated since her injury without recovery by another doctor. I feel she is a candidate for psychological/psychiatric intervention to her ongoing complaints, but it is not related to the sprain/strain injury, which should have resolved in 6 to 8 weeks.

I do not feel she is a candidate for the chronic pain management program since she has failed care to this point, but to the psychological treatment for the stressors that have been and are ongoing in her life situation. Findings on exam with straight leg testing of only 10 degrees would raise a "red flag" to symptom magnification and somatization of pain perceived; psychological component present to pain reported in my opinion.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) days of your receipt of this decision (20 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P.O. Box 40669, Austin, Texas, 78704-0012. **A copy of this decision should be attached to the request.**

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute (Commission Rule 133.308 (t)(2)).

This decision by the IRO is deemed to be a TWCC decision and order.